APPENDIX 9
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION DAY TREATMENT ATTACHMENT (PA/DTA)

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Attn: Prior Authorization, Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) or the Prior Authorization Day Treatment Attachment (PA/DTA) may be addressed to EDS' Correspondence Unit for Policy/Billing Information. Refer to Appendix 2 of Part A of the Wisconsin Medical Assistance Program (WMAP) provider handbook for the telephone numbers.

RECIPIENT INFORMATION

ELEMENT 1 - RECIPIENT'S LAST NAME
Indicate the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Indicate the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Indicate the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Indicate the recipient's ten-digit Medical Assistance number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Indicate the age of the recipient in numerical form.

PROVIDER INFORMATION

ELEMENT 6 - REQUESTING/PERFORMING PROVIDER'S NAME AND CREDENTIALS
Indicate the name and the credentials of the provider requesting prior authorization.

ELEMENT 7 - REQUESTING/PERFORMING PROVIDER NUMBER
Indicate the eight-digit Medical Assistance provider number of the provider requesting prior authorization.

ELEMENT 8 - REQUESTING/PERFORMING PROVIDER'S TELEPHONE NUMBER
Indicate the telephone number, including area code, of the requesting provider.

ELEMENT 9 - REFERRING/PRESCRIBING PROVIDER'S NAME
Indicate the name of the referring/prescribing provider.

ELEMENT 10 - REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Indicate the eight-digit Medical Assistance provider number of the referring/prescribing provider.

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"Day Treatment" or "Day Hospital" means a non-residential program in a medically supervised setting that provides case management, medical care, psychotherapy and other therapies, including recreational, physical, occupational and speech therapies and follow-up services, to alleviate problems related to mental illness or emotional disturbances. Day treatment services are provided by an interdisciplinary team on a routine, continuous basis for a scheduled portion of a 24-hour day and may include structural rehabilitative activities including training in basic living skills, interpersonal skills and problem-solving skills." HSS 101.03(37).

The target population for extended day treatment services are the chronically mentally ill (CMI) or those that have an acute exacerbation of a chronic mental disorder (supported by diagnosis and narrative summary).

Rehabilitation
This category is used for all of the target day treatment population who may benefit by intensive day treatment.

Maintenance
This category is for those recipients, who by diagnosis and history, are suffering from a chronic mental disorder as indicated by diagnosis, signs of illness for two or more years, and past intensive day treatment has already been tried for six months, or more with no apparent change in functional assessment and/or narrative history. The major goal of treatment here is to maintain the individual in the community and prevent hospitalization.

Stabilization
This category is for those recipients in the target population who decompensate and/or have an acute exacerbation of a chronic condition. The goal in this category is to increase structure to stabilize the recipient, to prevent harm to self and/or others, and/or to prevent hospitalization. Decompensation would be indicated by a recent hospitalization (i.e., within the last 30 days) and/or other acceptable signs of clear deterioration (in level and course of functioning).

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The remaining portions of this attachment are to be used to document the justification for the service requested.

1. Complete elements A-N. The recipient's signature in element M is optional. The signature of the 51.42 Board Director, in element N, is not required.

2. Attach a photocopy of the demographic sheet of the functional assessment form to this attachment.

3. Attach a photocopy of the physician's current prescription for medical day treatment to the attachment form. The prescription must be dated within one month of receipt by EDS.

4. Read the Prior Authorization Statement before dating and signing the attachment.

5. The attachment must be dated and signed by the provider requesting or providing the service.